FOR OHF USE

LL1

2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0041939

Facility Name: WILLOWCREEK REHAB. & NURSING CENTER, LLC

Address: 40 N. 64TH STREET (Number) BELLEVILLE (City) 62223 (Zip Code)

County: ST. CLAIR COUNTY

Telephone Number: (618) 397-8400 **Fax #** (618) 397-8470

IDPA ID Number: 36-4084188

Date of Initial License for Current Owners: 06/01/96

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve N. Lavenda **Telephone Number:** (847) 236-1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/00 to 12/31/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment

Officer or Administrator of Provider	(Signed)	(Date)
	(Type or Print Name)	
	(Title)	
Paid Preparer	(Signed)	SEE ACCOUNTANT'S REPORT ATTACHED (Date)
	(Print Name and Title)	MARVIN FOX, C.P.A.
	(Firm Name & Address)	FROST, RUTTENBERG & ROTHBLATT, P.C. 111 Pfingsten Rd. , Suite 300, Deerfield, Il 60015
	(Telephone)	(847) 236-1111 Fax # (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number WILLOWCREEK REHAB. & NURSING CENTER, LLC # 0041939 Report Period Beginning: 01/01/00 Ending: 12/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	61	Skilled (SNF)	60	22,212	1
2		Skilled Pediatric (SNF/PED)			2
3	61	Intermediate (ICF)	62	22,440	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	122	TOTALS	122	44,652	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	18,420	1,168	7,886	27,474	8
9	SNF/PED					9
10	ICF	11,423	1,237		12,660	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	29,843	2,405	7,886	40,134	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.88%

D. How many bed-hold days during this year were paid by Public Aid? 123 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 06/01/96

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 06/01/96 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 122 and days of care provided 6,263

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/99 Fiscal Year: 12/31/99

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number WILLOWCREEK REHAB. & NURSING CI # 0041939 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	155,363	29,564	9,177	194,104		194,104	11,241	205,345			1
2	Food Purchase		152,390		152,390	(12,737)	139,653	(91)	139,562			2
3	Housekeeping	108,867	30,375		139,242		139,242		139,242			3
4	Laundry	56,423	31,056		87,479		87,479		87,479			4
5	Heat and Other Utilities			91,399	91,399		91,399	1,046	92,445			5
6	Maintenance	59,426		70,039	129,465		129,465	(5,424)	124,041			6
7	Other (specify):*											7
8	**TOTAL General Services**	380,079	243,385	170,615	794,079	(12,737)	781,342	6,772	788,114			8
	B. Health Care and Programs											
9	Medical Director			7,200	7,200		7,200		7,200			9
10	Nursing and Medical Records	1,777,277	166,615	527,923	2,471,815		2,471,815	(18,650)	2,453,165			10
10a	Therapy	475,803	14,124	41,486	531,413		531,413	(3,462)	527,951			10a
11	Activities	39,243	2,171		41,414		41,414		41,414			11
12	Social Services	8,994		2,775	11,769		11,769		11,769			12
13	Nurse Aide Training			255	255		255		255			13
14	Program Transportation											14
15	Other (specify):*							3,246	3,246			15
16	**TOTAL Health Care and Programs**	2,301,317	182,910	579,639	3,063,866		3,063,866	(18,866)	3,045,000			16
	C. General Administration											
17	Administrative	72,124		275,325	347,449		347,449	(190,427)	157,022			17
18	Directors Fees											18
19	Professional Services			85,660	85,660	(1,767)	83,893	2,085	85,978			19
20	Dues, Fees, Subscriptions & Promotions			50,063	50,063		50,063	(15,311)	34,752			20
21	Clerical & General Office Expenses	115,480	57,931	188,934	362,345		362,345	(62,202)	300,143			21
22	Employee Benefits & Payroll Taxes			403,710	403,710	12,737	416,447		416,447			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,374	2,374		2,374	454	2,828			24
25	Other Admin. Staff Transportation			27,153	27,153		27,153	1,395	28,548			25
26	Insurance-Prop.Liab.Malpractice			55,823	55,823		55,823	55	55,878			26
27	Other (specify):*							23,023	23,023			27
28	**TOTAL General Administration**	187,604	57,931	1,089,042	1,334,577	10,970	1,345,547	(240,928)	1,104,619			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,869,000	484,226	1,839,296	5,192,522	(1,767)	5,190,755	(253,022)	4,937,733			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

WILLOWCREEK REHAB. & NURSING CENTER, LLC
0041939
COST REPORT RECLASSIFICATIONS
01/01/00
12/31/00

SCHEDULE V LINE #			
22	EMPLOYEE BENEFITS	12,737	
2	FOOD		12,737

To reclass cost of employee meals from raw food to employee benefits

33	REAL ESTATE TAX	1,767	
19	PROFESSIONAL FEES		1,767

To reclass cost of appealing real estate taxes

Facility Name & ID Number WILLOWCREEK REHAB. & NURSING CENTER, LLC #0041939 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			67,384	67,384		67,384	(12,594)	54,790			30
31	Amortization of Pre-Op. & Org.			9,699	9,699		9,699		9,699			31
32	Interest			141,535	141,535		141,535	3,871	145,406			32
33	Real Estate Taxes			48,390	48,390	1,767	50,157		50,157			33
34	Rent-Facility & Grounds			404,482	404,482		404,482	9,062	413,544			34
35	Rent-Equipment & Vehicles			11,433	11,433		11,433	1,088	12,521			35
36	Other (specify):*											36
37	**TOTAL Ownership**			682,923	682,923	1,767	684,690	1,427	686,117			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		1,121,352	695,994	1,817,346		1,817,346	(143,452)	1,673,894			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			66,978	66,978		66,978		66,978			42
43	Other (specify):*	46,088			46,088		46,088	(46,088)				43
44	**TOTAL Special Cost Centers**	46,088	1,121,352	762,972	1,930,412		1,930,412	(189,540)	1,740,872			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,915,088	1,605,578	3,285,191	7,805,857		7,805,857	(441,135)	7,364,722			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number WILLOWCREEK REHAB. & NURSING CENTER, LLC # 0041939 Report Period Beginning: 01/01/00 Ending: 12/31/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(29,349)	30		9
10	Interest and Other Investment Income	(409)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(91)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(10,720)	21		18
19	Entertainment	(18)	21		19
20	Contributions	(1,500)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(101,681)	21		24
25	Fund Raising, Advertising and Promotional	(11,654)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(6,309)	20		28
29	Other-Attach Schedule	(88,038)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (249,769)		$	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(191,366)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (191,366)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (441,135)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

WILLOWCREEK REHAB. & NURSING CENTER, LLC

ID# 0041939

Report Period Beginning: 01/01/00

Ending: 12/31/00

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Deferred Maintenance	$	6	1
2	IL COUNCIL LTC - NON ALLOW	(196)	21	2
3	BANK CHARGES	(35,552)	21	3
4	MARKETING SALARY	(46,088)	43	4
5	CAPITALIZED REPAIRS AND MAINTENANCE	(4,924)	6	5
6	CAPITALIZED PAINTING & DECORATING	(858)	6	6
7	PRIOR YEAR LEGAL	(420)	19	7
8				8
9				9
10				10
11				11
12				12
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87				87
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89				89
90	**Total**	(88,038)		90

STATE OF ILLINOIS — Summary A

Facility Name & ID Number WILLOWCREEK REHAB. & NURSING CENTER, LLC # 0041939 Report Period Beginning: 01/01/00 Ending: 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
1	Dietary					11,241							11,241	1
2	Food Purchase	(91)											(91)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities			1,046									1,046	5
6	Maintenance	(5,782)		358									(5,424)	6
7	Other (specify):*													7
8	**TOTAL General Services**	(5,873)		1,404		11,241							6,772	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records			20,218		(38,868)							(18,650)	10
10a	Therapy						(3,462)						(3,462)	10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*			3,246									3,246	15
16	**TOTAL Health Care and Programs**			23,464		(38,868)	(3,462)						(18,866)	16
	C. General Administration													
17	Administrative			(190,427)									(190,427)	17
18	Directors Fees													18
19	Professional Services	(420)		2,505									2,085	19
20	Fees, Subscriptions & Promotions	(17,963)		2,652									(15,311)	20
21	Clerical & General Office Expenses	(149,667)		87,465									(62,202)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			454									454	24
25	Other Admin. Staff Transportation			1,395									1,395	25
26	Insurance-Prop.Liab.Malpractice			55									55	26
27	Other (specify):*			23,023									23,023	27
28	**TOTAL General Administration**	(168,050)		(72,878)									(240,928)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(173,923)		(48,010)		(27,627)	(3,462)						(253,022)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number WILLOWCREEK REHAB. & NURSING CENTER, LLC # 0041939 Report Period Beginning: 01/01/00 Ending: 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	(29,349)		16,755									(12,594)	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(409)		4,280									3,871	32
33	Real Estate Taxes													33
34	Rent-Facility & Grounds			9,062									9,062	34
35	Rent-Equipment & Vehicles			1,088									1,088	35
36	Other (specify):*													36
37	**TOTAL Ownership**	(29,758)		31,185									1,427	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers					(28,581)	(114,871)						(143,452)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(46,088)											(46,088)	43
44	**TOTAL Special Cost Centers**	(46,088)				(28,581)	(114,871)						(189,540)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(249,769)		(16,825)		(56,208)	(118,333)						(441,135)	45

Facility Name & ID Number WILLOWCREEK REHAB. & NURSING CENTER, LLC # 0041939 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTACHED		SEE ATTACHED		SEE ATTACHED		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number WILLOWCREEK REHAB. & NURSING CENTER, LLC # 0041939 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	QUALITY CARE MANAGEMENT	100.00%	$ 1,046	$ 1,046	15
16	V	6	REPAIRS AND MAINT.		QUALITY CARE MANAGEMENT	100.00%	358	358	16
17	V	10	SAL-NURSING		QUALITY CARE MANAGEMENT	100.00%	20,218	20,218	17
18	V	15	EMP. BEN.-H.C.		QUALITY CARE MANAGEMENT	100.00%	3,246	3,246	18
19	V	17	ADMIN SAL-NON-OWNER		QUALITY CARE MANAGEMENT	100.00%	3,656	3,656	19
20	V	17	ADMIN. SAL.- A. SALTZMAN		QUALITY CARE MANAGEMENT	100.00%	14,676	14,676	20
21	V	17	ADMIN. SAL - B BENOUDIZ		QUALITY CARE MANAGEMENT	100.00%	14,147	14,147	21
22	V	17	ADMIN. SAL. - B. CLOCH		QUALITY CARE MANAGEMENT	100.00%	35,479	35,479	22
23	V	17	ADMIN. SAL. - B. TEITELBAUM		QUALITY CARE MANAGEMENT	100.00%	3,860	3,860	23
24	V	17	ADMIN. SAL - J. MEISELS		QUALITY CARE MANAGEMENT	100.00%	1,588	1,588	24
25	V	17	ADMIN. SAL. - MIKE FILIPPO		QUALITY CARE MANAGEMENT	100.00%	11,492	11,492	25
26	V	19	PROFESSIONAL FEES		QUALITY CARE MANAGEMENT	100.00%	2,505	2,505	26
27	V	20	FEES,SUBSCRIPTIONS		QUALITY CARE MANAGEMENT	100.00%	2,652	2,652	27
28	V	21	CLERICAL & GENERAL		QUALITY CARE MANAGEMENT	100.00%	87,465	87,465	28
29	V	24	EDUCATION & SEMINAR		QUALITY CARE MANAGEMENT	100.00%	454	454	29
30	V	25	OTHER ADMIN. STAFF TRANS.		QUALITY CARE MANAGEMENT	100.00%	1,395	1,395	30
31	V	26	INSURANCE		QUALITY CARE MANAGEMENT	100.00%	55	55	31
32	V	27	EMP. BEN.-GEN. ADMIN.		QUALITY CARE MANAGEMENT	100.00%	23,023	23,023	32
33	V	30	DEPRECIATION		QUALITY CARE MANAGEMENT	100.00%	16,755	16,755	33
34	V	32	INTEREST		QUALITY CARE MANAGEMENT	100.00%	4,280	4,280	34
35	V	34	OFFICE RENT-UNRELATED		QUALITY CARE MANAGEMENT	100.00%	9,062	9,062	35
36	V	35	EQUIPMENT RENTAL		QUALITY CARE MANAGEMENT	100.00%	1,088	1,088	36
37	V								37
38	V	17	CORPORATE ALLOCATION	275,325	QUALITY CARE MANAGEMENT	100.00%		(275,325)	38
39	Total			$ 275,325			$ 258,500	$ * (16,825)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WILLOWCREEK REHAB. & NURSING CENTER, LLC # 0041939 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	6	REPAIRS AND MAINT.	$ 0	QUALITY CARE MANAGEMENT	100.00%	$ 0	$	15
16	V	7	EMP. BEN.-GEN. SERV.		QUALITY CARE MANAGEMENT	100.00%	0		16
17	V								17
18	V	1	DIETICIAN SALARIES	0	QUALITY CARE MANAGEMENT	100.00%	0		18
19	V	7	EMP. BEN.-GEN. ADMIN.		QUALITY CARE MANAGEMENT	100.00%	0		19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WILLOWCREEK REHAB. & NURSING CENTER, LLC # 0041939 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	MEDICAL/TUBE FEED-MDCR	$ 45,195	QUALITY CARE MEDICAL SUPPLY	100.00%	$ 16,614	$ (28,581)	15
16	V	10	MEDICAL SUPPLIES	43,686	QUALITY CARE MEDICAL SUPPLY	100.00%	4,818	(38,868)	16
17	V	1	FOOD SUPPLEMENTS		QUALITY CARE MEDICAL SUPPLY	100.00%	11,241	11,241	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 88,881			$ 32,673	$ * (56,208)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WILLOWCREEK REHAB. & NURSING CENTER, LLC # 0041939 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10A	REHAB CONSULTING	$ 20,486	ADVANCED THERAPY & REHAB, L.L.C.	100.00%	$ 17,024	$ (3,462)	15
16	V	39	ANCILLARY REHAB	679,710	ADVANCED THERAPY & REHAB, L.L.C.	100.00%	564,839	(114,871)	16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 700,196			$ 581,863	$ * (118,333)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WILLOWCREEK REHAB. & NURSING CENTER, LLC # 0041939 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number WILLOWCREEK REHAB. & NURSING CENTER, LLC # 0041939 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number WILLOWCREEK REHAB. & NURSING CENTER, LLC # 0041939 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WILLOWCREEK REHAB. & NURSING CENTER, LLC # 0041939 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number WILLOWCREEK REHAB. & NURSING CENTER, LLC # 0041939 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WILLOWCREEK REHAB. & NURSING C # 0041939 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	BRIAN CLOCH	OWNER	ADMIN	46.00	SEE ATTACHED	9.2	14.09	ALLOC-QCM	$ 35,479	17-7	1
2	BETH BENOUDIZ	CFO	ADMIN	4.00	SEE ATTACHED	5.7	11.40	ALLOC-QCM	14,147	17-7	2
3	DAVID MEISELS	OWNER	ADMIN	46.00	SEE ATTACHED	5	9.09				3
4	AMY SALTZMAN	OWNER	ADMIN	4.00	SEE ATTACHED	10	20.00	ALLOC-QCM	14,676	17-7	4
5	BRUCHA TEITELBAUM	RELATIVE	ADMIN		SEE ATTACHED	0.6	1.50	ALLOC-QCM	3,860	17-7	5
6	JOSEPH MEISELS	RELATIVE	ADMIN		SEE ATTACHED	2.3	4.59	ALLOC-QCM	1,588	17-7	6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 69,750		13

*** If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.**

**** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees) FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.**

Facility Name & ID Number WILLOWCREEK REHAB. & NURSING CENTER, LL(# 0041939 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number (
Fax Number (

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1										1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number WILLOWCREEK REHAB. & NURSING CENTER, LL(# 0041939 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: QUALITY CARE MANAGEMENT
Street Address: 8950 GROSS POINT RD. #E
City / State / Zip Code: SKOKIE, IL. 60077
Phone Number: (847) 663-1155
Fax Number: (847) 663-0917

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	PATIENT DAYS	352,747	6	$ 9,193	$	40,134	$ 1,046	1
2	6	REPAIRS AND MAINT.	PATIENT DAYS	352,747	6	3,145		40,134	358	2
3	10	SAL-NURSING	PATIENT DAYS	352,747	6	177,703	177,703	40,134	20,218	3
4	15	EMP. BEN.-H.C.	PATIENT DAYS	352,747	6	28,527		40,134	3,246	4
5	17	ADMIN SAL-NON-OWNER	PATIENT DAYS	352,747	6	32,137	32,137	40,134	3,656	5
6	17	ADMIN. SAL.- A. SALTZMAN	PATIENT DAYS	352,747	6	128,995	128,995	40,134	14,676	6
7	17	ADMIN. SAL - B BENOUDIZ	PATIENT DAYS	352,747	6	124,342	124,342	40,134	14,147	7
8	17	ADMIN. SAL. - B. CLOCH	PATIENT DAYS	352,747	6	311,829	311,829	40,134	35,479	8
9	17	ADMIN. SAL. - B. TEITELBAUM	PATIENT DAYS	352,747	6	33,925	33,925	40,134	3,860	9
10	17	ADMIN. SAL - J. MEISELS	PATIENT DAYS	352,747	6	13,958	13,958	40,134	1,588	10
11	17	ADMIN. SAL. - MIKE FILIPPO	PATIENT DAYS	352,747	6	101,006	101,006	40,134	11,492	11
12	19	PROFESSIONAL FEES	PATIENT DAYS	352,747	6	22,013		40,134	2,505	12
13	20	FEES,SUBSCRIPTIONS	PATIENT DAYS	352,747	6	23,307		40,134	2,652	13
14	21	CLERICAL & GENERAL	PATIENT DAYS	352,747	6	768,752	651,494	40,134	87,465	14
15	24	EDUCATION & SEMINAR	PATIENT DAYS	352,747	6	3,989		40,134	454	15
16	25	OTHER ADMIN. STAFF TRANS	PATIENT DAYS	352,747	6	12,263		40,134	1,395	16
17	26	INSURANCE	PATIENT DAYS	352,747	6	485		40,134	55	17
18	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	352,747	6	202,353		40,134	23,023	18
19	30	DEPRECIATION	PATIENT DAYS	352,747	6	147,266		40,134	16,755	19
20	32	INTEREST	PATIENT DAYS	352,747	6	37,619		40,134	4,280	20
21	34	OFFICE RENT-UNRELATED	PATIENT DAYS	352,747	6	79,644		40,134	9,062	21
22	35	EQUIPMENT RENTAL	PATIENT DAYS	352,747	6	9,564		40,134	1,088	22
23										23
24										24
25	TOTALS					$ 2,272,015	$ 1,575,389		$ 258,500	25

Facility Name & ID Number WILLOWCREEK REHAB. & NURSING CENTER, LL(# 0041939 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: QUALITY CARE MANAGEMENT
Street Address: 8950 GROSS POINT RD. #E
City / State / Zip Code: SKOKIE, IL. 60077
Phone Number: (847) 663-1155
Fax Number: (847) 663-0917

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	REPAIRS AND MAINT.	PAINTING REVENUE	21,912	5	$ 56,124	$ 56,124		$	1
2	7	EMP. BEN.-GEN. SERV.	PAINTING REVENUE	21,912	5	9,010				2
3										3
4	1	DIETICIAN SALARIES	DIETICIAN REVENUE	18,893	6	20,480	20,480			4
5	7	EMP. BEN.-GEN. ADMIN.	DIETICIAN REVENUE	18,893	6	$ 3,288	$		$	5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 88,902	$ 76,604		$	25

Facility Name & ID Number WILLOWCREEK REHAB. & NURSING CENTER, LL(# 0041939 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Quality Care Medical Supply
Street Address: 8950 Gross Point Rd. #E
City / State / Zip Code: Skokie, IL 60077
Phone Number: ((847)663-1155
Fax Number: ((847)663-0917

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	39	MEDICAL/TUBE FEED-MDCR	DIRECT ALLOCATION						16,614	1
2	10	MEDICAL SUPPLIES	DIRECT ALLOCATION						4,818	2
3	1	FOOD SUPPLEMENTS	DIRECT ALLOCATION						11,241	3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 32,673	25

Facility Name & ID Number WILLOWCREEK REHAB. & NURSING CENTER, LL(# 0041939 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Advanced Therapy & Rehab., L.L.C.
Street Address: 8950 Gross Point Rd. #E
City / State / Zip Code: Skokie, IL 60077
Phone Number: (847)663-1155
Fax Number: (847)663-0917

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10A	REHAB CONSULTING	DIRECT ALLOCATION						17,024	1
2	39	ANCILLARY REHAB	DIRECT ALLOCATION						564,839	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 581,863	25

Facility Name & ID Number WILLOWCREEK REHAB. & NURSING CENTER, LL(# 0041939 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number WILLOWCREEK REHAB. & NURSING CENTER, LL(# 0041939 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number WILLOWCREEK REHAB. & NURSING CENTER, LL(# 0041939 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number WILLOWCREEK REHAB. & NURSING CENTER, LL(# 0041939 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number WILLOWCREEK REHAB. & NURSING CENTER, LL(# 0041939 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number WILLOWCREEK REHAB. & NURSING Cl # 0041939 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	CORUS BANK		X	LINE OF CREDIT	INT ONLY	9/05/97	1,100,000	1,075,000	DEMAND	PRIME+.5	104,396	6
7	CORUS BANK		X	WORKING CAPITAL	$10,417.00	6/01/99	125,000		5/01/00	PRIME+.5	1,220	7
8	MANUFACTURER'S BANK		X	WORKING CAPITAL	VARIES	7/12/00	300,000	275,000	7/12/01	9.5000	11,674	8
9	TOTAL Facility Related				$10,417.00		$ 1,525,000	$ 1,350,000			$ 117,291	9
	B. Non-Facility Related*											
10	Supplemental Schedule							352,500			28,115	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$ 352,500			$ 28,115	14
15	TOTALS (line 9+line14)						$ 1,525,000	$ 1,702,500			$ 145,406	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number WILLOWCREEK REHAB. & NURSING CEN # 0041939 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
1	CHMIT	X		WORKING CAPITAL	N/A	06/01/96	$ 182,500	$ 182,500	DEMAND	8.00%	$ 14,600	1
2	J. ROSIN		X	WORKING CAPITAL	INT ONLY	05/12/97	100,000	75,000	DEMAND	9.50%	7,144	2
3	BELLEVILLE ASSOC.		X	SECURITY DEPOSIT LOAN	N/A	06/01/97	25,000	25,000	N/A	10.00%	2,500	3
4	ALLOC FROM QCM	X									4,280	4
5	CONTINENTAL CARE CTR	X						30,000				5
6	FOX RIVER PAVILION	X						40,000				6
7	INTEREST INCOME										(409)	7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21							$ 307,500	$ 352,500			$ 28,115	21

Facility Name & ID Number WILLOWCREEK REHAB. & NURSING CENTER, LLC # 0041939 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	48,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	47,390	2
3. Under or (over) accrual (line 2 minus line 1).	$	(610)	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	49,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	1,767	5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6	$	50,157	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1995		8
1996		9
1997	77,314	10
1998	46,265	11
1999	47,390	12

2000 ACCRUAL = $47,389 X 1.03 = $49,000 ROUNDED

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number WILLOWCREEK REHAB. & NURSING CENTER, LLC # 0041939 Report Period Beginning: 01/01/00 Ending: 12/31/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: _____ B. General Construction Type: Exterior BRICK Frame BRICK Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

NONE

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 30,994
2. Number of Years Over Which it is Being Amortized: 5 YEARS
3. Current Period Amortization: 9,699
4. Dates Incurred: 1996, 1998 AND 2000

Nature of Costs: $20,994 ORGANIZATION COSTS; $10,000 LOAN COSTS
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number WILLOWCREEK REHAB. & NURSING CENTER, LLC # 0041939 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	LAWN MASTERS			1996	5,658	145	20	283	138	1,274	9
10	R.WIESEN PAINTER			1996	925	24	20	46	22	188	10
11	PAINTING&DECORATING			1996	5,479		20	274	274	1,187	11
12	WALLPAPER			1996	1,096	28	20	55	27	248	12
13	WILKE WINDOWS			1996	3,493	90	20	175	85	788	13
14	R/WIESEN PAINTER			1996	1,261	32	20	63	31	273	14
15	HINKLE PLUMBING			1996	1,133	29	20	57	28	252	15
16	R.WIESEN PAINTER			1996	2,224	57	20	111	54	490	16
17	GRAND OAKS			1996	1,103	28	20	55	27	248	17
18	PHONE SYSTEM			1996	10,758	1,027	20	538	(489)	2,466	18
19	R.WIESEN PAINTER			1996	1,335	34	20	67	33	285	19
20	CONSTRUCTION			1996	5,991	154	20	300	146	1,275	20
21	ALARM SYSTEM			1996	4,745	122	20	237	115	1,007	21
22	PLUMBING			1996	1,406	36	20	70	34	298	22
23	R.WIESEN PAINTER			1996	1,363	35	20	68	33	283	23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32	PAGE 12D TOTALS				45,159	5,112		2,152	(2,960)	2,636	32
33	PAGE 12C TOTALS				110,125	2,542		5,534	2,992	10,761	33
34	PAGE 12B TOTALS				70,276	1,762		3,596	1,834	11,924	34
35	PAGE 12A TOTALS				66,172	1,632		3,310	1,678	12,818	35
36	TOTAL (lines 4 thru 35)				$ 339,702	$ 12,889		$ 16,991	$ 4,102	$ 48,701	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WILLOWCREEK REHAB. & NURSING CENTER, LLC # 0041939 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	HINKLE PLUMBING			1996	4,625	119	20	231	112	1,001	9
10	R.WEISEN PAINTER			1996	1,637	42	20	82	40	369	10
11	GRAND OAKS			1996	5,218	134	20	261	127	1,175	11
12	RIVIESEN PAINTER			1997	2,111	54	20	106	52	406	12
13	LIGHT FIXTURES			1997	755	19	20	38	19	146	13
14	PLUMBING			1997	1,197	31	20	60	29	225	14
15	CARPETING			1997	9,674	248	20	484	236	1,896	15
16	HANDRAILS			1997	2,707	69	20	135	66	529	16
17	WALLPAPER			1997	3,812	98	20	191	93	764	17
18	R.WIESEN PAINTER			1997	2,655	68	20	133	65	499	18
19	TILE FLOOR			1997	2,200	56	20	110	54	440	19
20	CARPETING			1997	2,653	68	20	133	65	499	20
21	FLOORING			1997	1,806	46	20	90	44	338	21
22	HINKLE PLUMBING			1997	1,325	34	20	66	32	248	22
23	LUMBER			1997	1,266	32	20	63	31	215	23
24	WINDOW TREATMENTS			1997	1,454		20	73	73	256	24
25	PAINTING & DECORATNG			1997	6,092		20	305	305	1,068	25
26	WALLPAPER			1997	745	19	20	37	18	148	26
27	REFRIG COMPRESSOR			1997	929	107	20	46	(61)	184	27
28	AUTOMATIC DOOR			1997	1,560	40	20	78	38	280	28
29	GREASE TRAP			1997	515	59	20	26	(33)	98	29
30	A/C UNIT			1997	634	16	20	32	16	112	30
31	LANDSCAPING			1997	800	21	20	40	19	147	31
32	SECURITY SYSTEM			1997	1,228	31	20	61	30	219	32
33	STORAGE SHED			1997	4,200	108	20	210	102	753	33
34	COUNTER TOPS			1997	1,038	27	20	52	25	191	34
35	R.WIESEN PAINTER			1997	3,336	86	20	167	81	612	35
36	TOTAL (lines 4 thru 35)				$ 66,172	$ 1,632		$ 3,310	$ 1,678	$ 12,818	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WILLOWCREEK REHAB. & NURSING CENTER, LLC # 0041939 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	TILE KITCHEN			1997	9,752	250	20	488	238	1,749	9
10	LIGHT FIXTURES			1997	2,500	64	20	125	61	417	10
11	R.WIESEN PAINTER			1997	927	24	20	46	22	165	11
12	R.WIESEN PAINTER			1997	1,760	45	20	88	43	352	12
13	WALLPAPER			1997	1,022	26	20	51	25	174	13
14	DRAPERIES			1997	5,894	151	20	295	144	959	14
15	WATER HEATER			1997	5,285	136	20	264	128	968	15
16	R.WEISSEN PAINTER			1997	2,099	54	20	105	51	411	16
17	A/C PARTS			1997	1,155	30	20	58	28	203	17
18	HANDRAILS			1997	6,469	166	20	323	157	1,023	18
19	TOILETS			1997	981	25	20	49	24	196	19
20	GUTTER DRAINAGE SYS			1997	1,686	43	20	84	41	308	20
21	DRAPERIES			1997	1,644		20	164	164	656	21
22	R.WIESEN PAINTER			1997	1,386	36	20	69	33	213	22
23	R.WIESEN PAINTER			1997	1,170	30	20	59	29	187	23
24	WALLPAPER			1997	3,032	78	20	152	74	481	24
25	CARPET			1997	9,320	239	20	466	227	1,476	25
26	ROWLAND ELECTRIC			1997	535	14	20	27	13	83	26
27	TILE			1998	2,222	57	20	111	54	333	27
28	R WEISEN-PAINTER			1998	1,503	39	20	75	36	219	28
29	R WEISEN-PAINTER			1998	1,449	37	20	72	35	216	29
30	FLOOR TILE			1998	851	22	20	43	21	100	30
31	CARPETING			1998	3,439	88	20	172	84	502	31
32	WALL PAPER			1998	884	23	20	44	21	128	32
33	GUTTERS			1998	983	25	20	49	24	143	33
34	DOOR OPENERS			1998	531	14	20	27	13	74	34
35	WALLPAPER			1998	1,797	46	20	90	44	188	35
36	TOTAL (lines 4 thru 35)				$ 70,276	$ 1,762		$ 3,596	$ 1,834	$ 11,924	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WILLOWCREEK REHAB. & NURSING CENTER, LLC # 0041939 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	PLUMBING			1998	1,295	33	20	65	32	173	9
10	GUTTER DRAINAGE SYST			1998	2,000	51	20	100	49	250	10
11	ROOF WORK			1998	2,400	62	20	120	58	360	11
12	PAINTING&DECORATING			1998	7,271		20	364	364	910	12
13	FLOORING			1998	1,947	50	20	97	47	218	13
14	HANDRAILS			1998	2,443	63	20	122	59	254	14
15	T GRODEK			1998	2,375	61	20	119	58	248	15
16	COVE BASE			1998	703	18	20	35	17	79	16
17	FLOOR TILE			1998	2,110	54	20	106	52	239	17
18	GENERATOR MAINT			1999	2,343	60	20	117	57	166	18
19	PLUMBING			1999	3,431	88	20	172	84	315	19
20	CARPETING			1999	1,263	32	20	63	31	95	20
21	GENERATOR			1999	28,102	721	20	1,405	684	2,810	21
22	COVE BASE			1999	524	168	20	52	(116)	56	22
23	ALUMINUM COLUMNS			1999	3,158	81	20	158	77	277	23
24	PIPING			1999	2,050	53	20	103	50	189	24
25	CHAIR RAILS			1999	1,134	29	20	57	28	100	25
26	SHED			1999	3,176	81	20	159	78	239	26
27	GENERATOR WIRING			1999	16,900	433	20	845	412	1,690	27
28	CONCRETE GENERATOR P			1999	2,325	60	20	116	56	232	28
29	INSTALL DRAIN			1999	630		20	32	32	64	29
30	TILE			1999	1,823	47	20	91	44	159	30
31	WALLPAPER & RAIL			1999	750		20	38	38	76	31
32	FLOORING			1999	11,574	297	20	579	282	724	32
33	PAINTING & DECOR			1999	6,548		20	327	327	654	33
34	WALLPAPER & RAIL			1999	925		20	46	46	92	34
35	WALLPAPER & RAIL			1999	925		20	46	46	92	35
36	TOTAL (lines 4 thru 35)				$ 110,125	$ 2,542		$ 5,534	$ 2,992	$ 10,761	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WILLOWCREEK REHAB. & NURSING CENTER, LLC # 0041939 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	TILE			1999	3,557	91	20	178	87	326	9
10	WALLPAPER & RAIL			1999	925		20	46	46	92	10
11	WALL SINK			1999	1,156	30	20	58	28	102	11
12	ECONCARE			1999	14,757	4,722	20	1,476	(3,246)	1,722	12
13	SEAL SERVICE ROAD			2000	2,170		20	7	7	7	13
14	ELECTRICAL WIRING			2000	2,722	67	20	67		67	14
15	PAINTING & DECOR			2000	858		20	43	43	43	15
16	A/C COMPRESSOR			2000	550		20	28	28	28	16
17	VENT UNIT MONITOR			2000	4,699	35	20	35		35	17
18	ROOF REPAIR			2000	7,801	92	20	92		92	18
19	FLOORING			2000	2,034	46	20	46		46	19
20	REPAIR GENERATOR			2000	2,059	29	20	29		29	20
21	GENERATOR REPAIR			2000	1,871		20	47	47	47	21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 45,159	$ 5,112		$ 2,152	$ (2,960)	$ 2,636	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WILLOWCREEK REHAB. & NURSING CENTER, LLC # 0041939 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
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27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WILLOWCREEK REHAB. & NURSING CENTER, LLC # 0041939 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
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28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WILLOWCREEK REHAB. & NURSING CENTER, LLC # 0041939 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
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28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WILLOWCREEK REHAB. & NURSING CENTER, LLC # 0041939 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
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27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WILLOWCREEK REHAB. & NURSING CENTER, LLC # 0041939 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
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28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WILLOWCREEK REHAB. & NURSING CENTER, LLC # 0041939 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
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28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WILLOWCREEK REHAB. & NURSING CENTER, LLC # 0041939 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
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29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WILLOWCREEK REHAB. & NURSING CENTER, LLC # 0041939 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
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29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WILLOWCREEK REHAB. & NURSING CENT # 0041939 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 329,015	$ 65,943	$ 32,905	$ (33,038)		$ 81,539	37
38	Current Year Purchases	22,207	3,808	3,827	19		3,827	38
39	Fully Depreciated Assets	7,675	1,499	1,067	(432)		7,675	39
40								40
41	TOTALS	$ 358,897	$ 71,250	$ 37,799	$ (33,451)		$ 93,041	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42				$	$	$	$		$	42
43										43
44										44
45										45
46	TOTALS			$	$	$	$		$	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 698,599	47	
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 84,139	48	
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 54,790	49	**
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ (29,349)	50	
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 141,742	51	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

WILLOWCREEK REHAB. & NURSING CENTER, LLC
0041939
RELATED COMPANY MOVABLE EQUIPMENT SCHEDULE
12/31/00

COMPANY NAME	COST	CURRENT BOOK (FED) DEPRECIATION	STRAIGHT LINE DEPRECIATION	ADJUSTMENTS	ACCUMULATED S/L DEPRECIATION
LINE 28: PRIOR YEARS					
WILLOWCREEK REHAB & NURSING	274,733	49,390	27,476	(21,914)	71,724
QUALITY CARE MANAGEMENT	54,282	16,553	5,429	(11,124)	9,815
TOTALS	329,015	65,943	32,905	(33,038)	81,539
LINE 29: CURRENT YEAR					
WILLOWCREEK REHAB & NURSING	20,785	3,606	3,774	168	3,774
QUALITY CARE MANAGEMENT	1,422	202	53	(149)	53
TOTALS	22,207	3,808	3,827	19	3,827
LINE 30: FULLY DEPRECIATED					
WILLOWCREEK REHAB & NURSING	7,675	1,499	1,067	(432)	7,675
QUALITY CARE MANAGEMENT					
TOTALS	7,675	1,499	1,067	(432)	7,675
TOTALS (Should Tie to Totals on Page 13)					
WILLOWCREEK REHAB & NURSING	303,193	54,495	32,317	(22,178)	83,173
QUALITY CARE MANAGEMENT	55,704	16,755	5,482	(11,273)	9,868
TOTALS	358,897	71,250	37,799	(33,451)	93,041

Facility Name & ID Number WILLOWCREEK REHAB. & NURSING CENTER, LLC # 0041939 Report Period Beginning: 01/01/00 Ending: 12/31/00

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: BELLEVILLE ASSOCIATES, INC.

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		122	05/16/96	$ 404,482	15	N/A	3
4	Additions							4
5			ALLOC FROM QUALITY CARE		9,062			5
6								6
7	TOTAL		122		$ 413,544 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [ ] YES [X] NO Terms: *

10. Effective dates of current rental agreement:
Beginning 05/31/96
Ending 05/31/11

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$ 414,594
13.	/2002	$ 424,958
14.	/2003	$ 435,582

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [X] YES [ ] NO

16. Rental Amount for movable equipment: $ 12,521 Description: COPIER=$10,309, FREEZER=$923, POSTAGE MACHINE=$201, ALLOC FROM QULAITY CARE=$1,088
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$ 0	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number WILLOWCREEK REHAB. & NURSING CENTER, LLC # 0041939 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$ 255	$	$ 255
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$ 255	$	$ 255
10	SUM OF line 9, col. 1 and 2 (e)	$ 255			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	hrs	$		$ 62,960	$		$ 62,960	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			26,269			26,269	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			585,092			585,092	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				219,023		219,023	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): **SEE SUPPLEMENTAL SCHEDULE**	39-2, 39-3				21,673	902,329		924,002	13
14	TOTAL			$		$ 695,995	$ 1,121,352		$ 1,817,346	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SUPPLEMENTAL SCHEDULE OF MEDICAL SUPPLIES

	Special Services - Supplies (Column 6 - Other)	Amount
1	Respiratory Therapy Supplies	607,111
2	Air Fluidized Beds	71,575
3	Tube Feeding	43,686
4	Oxygen	157,492
5	Arterial Blood Gas	720
6	Radiology	21,745
7		
8		
9		
10		
		902,329

	Outside Therapies (Column 5 - Other)	Amount
1	Laboratory	11,779
2	IV Therapy	9,894
3		
4		
5		
6		
7		
8		
9		
10		
		21,673

Facility Name & ID Number WILLOWCREEK REHAB. & NURSING CENTER, LLC # 0041939 Report Period Beginning: 01/01/00 Ending: 12/31/00

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/00 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ (181,470)	$	1
2	Cash-Patient Deposits	26,957		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,835,565		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	32,570		6
7	Other Prepaid Expenses	17,927		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See supplemental schedule	106,506		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,838,055	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cos	286,655		15
16	Equipment, at Historical Cost	331,270		16
17	Accumulated Depreciation (book methods)	(251,668)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	5,417		19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See supplemental schedule			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 371,674	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,209,729	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,114,335	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	26,957		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	130,118		30
31	Accrued Taxes Payable (excluding real estate taxes)	12,204		31
32	Accrued Real Estate Taxes(Sch.IX-B)	49,000		32
33	Accrued Interest Payable	77,601		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See supplemental schedule	1,115		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,411,330	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,702,500		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See supplemental schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,702,500	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,113,830	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (904,101)	$ #REF!	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,209,729	$ #REF!	48

*(See instructions.)

Facility Name & ID Number WILLOWCREEK REHAB. & NURSING CENTER, LL # 0041939 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

SUPPLEMENTAL SCHEDULE OF OTHER ASSETS & LIABILITIES **As of** 12/31/00

OTHER CURRENT ASSETS:	Amount	Amount
Real Estate Tax Escrow	27,345	
Security Depost	50,000	
Employee Advances	28,161	
Due to Members	1,000	
	106,506	

OTHER CURRENT LIABILITIES:	Amount	Amount
Wage Assignments	1,115	
	1,115	

OTHER NON CURRENT ASSETS:

Loan Costs

OTHER NON CURRENT LIABILITIES:

Facility Name & ID Number WILLOWCREEK REHAB. & NURSING CENTER, LLC # 0041939 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (218,239)	1
2	Restatements (describe):		2
3	**Schedule attached**		3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (218,239)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(685,862)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (685,862)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (904,101)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number	WILLOWCREEK REHAB. & NURSIN #	0041939	Report Period Beginning:	01/01/00	Ending:	12/31/00

Balance per General Ledger		(218,239)
Adjustments:		
		-
		-
		-
Total adjustments		-
Balance - Beginning of Year		(218,239)
Equity(Deficit) from Page 17 Col 1		(904,101)
Related Party		
Equity(Deficit)	0	
Income	0	
		-
Combined Equity - End of Year		(904,101)

Facility Name & ID Number WILLOWCREEK REHAB. & NURSING CENTE # 0041939 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 7,336,889	1
2	Discounts and Allowances for all Levels	(4,100,526)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,236,363	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,245,723	6
7	Oxygen	271,271	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 2,516,994	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	306,992	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	70,701	19
20	Radiology and X-Ray	38,663	20
21	Other Medical Services	946,218	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22**	$ 1,362,574	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	409	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 409	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See supplemental schedule	3,655	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 3,655	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,119,995	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	794,079	31
32	Health Care	3,063,866	32
33	General Administration	1,334,577	33
	B. Capital Expense		
34	Ownership	682,923	34
	C. Ancillary Expense		
35	Special Cost Centers	1,863,434	35
36	Provider Participation Fee	66,978	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,805,857	40
41	**Income before Income Taxes (line 30 minus line 40)****	(685,862)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (685,862)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? not complete If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number WILLOWCREEK REHAB. & NURS # 0041939 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

SUPPLEMENTAL SCHEDULE OF REVENUES
12/31/00

	DESCRIPTION	AMOUNT
1	Vending Commissions	2,522
2	State Replacement Tax	1,133
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		
13		
14		
15		
16		
17		
18		
19		
20		
	TOTALS	3,655

Facility Name & ID Number WILLOWCREEK REHAB. & NURSING CENTER, LLC # 0041939 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,953	2,194	$ 53,466	$ 24.37	1
2	Assistant Director of Nursing	1,837	1,998	40,133	20.09	2
3	Registered Nurses	23,617	27,155	515,611	18.99	3
4	Licensed Practical Nurses	21,525	22,796	356,768	15.65	4
5	Nurse Aides & Orderlies	77,030	91,208	778,611	8.54	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	29,702	35,203	475,803	13.52	8
9	Activity Director	949	1,033	9,572	9.27	9
10	Activity Assistants	3,447	3,766	29,671	7.88	10
11	Social Service Workers			8,994		11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	1,818	2,251	26,469	11.76	14
15	Cook Helpers/Assistants	19,651	25,221	128,894	5.11	15
16	Dishwashers					16
17	Maintenance Workers	4,395	5,161	59,426	11.51	17
18	Housekeepers	16,967	19,314	108,867	5.64	18
19	Laundry	9,700	10,469	56,423	5.39	19
20	Administrator	1,833	1,944	56,078	28.85	20
21	Assistant Administrator	309	326	4,948	15.18	21
22	Other Administrative	732	740	11,098	15.00	22
23	Office Manager					23
24	Clerical	12,925	14,425	115,480	8.01	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,780	3,986	32,688	8.20	31
32	Other Health Care(specify)					32
33	Other(specify) SEE SUPP	1,512	1,829	46,088	25.20	33
34	TOTAL (lines 1 - 33)	233,682	271,019	$ 2,915,088 *	$ 10.76	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	193	$ 9,177	1-3	35
36	Medical Director	96	7,200	9-3	36
37	Medical Records Consultant	23	900	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	48	720	10-3	39
40	Physical Therapy Consultant	197	8,865	10a-3	40
41	Occupational Therapy Consultant	258	11,621	10a-3	41
42	Respiratory Therapy Consultant	360	21,000	10a-3	42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	56	2,775	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,231	$ 62,258		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	3,450	$ 132,819	10-3	50
51	Licensed Practical Nurses	8,874	214,375	10-3	51
52	Nurse Aides	11,340	179,109	10-3	52
53	TOTAL (lines 50 - 52)	23,664	$ 526,303		53

Facility Name & ID Number WILLOWCREEK REHAB. & NURSING CENTER, LLC # 0041939 Report Period Beginning: 01/01/00 Ending: 12/31/00

SUPPLEMENTAL SCHEDULE OF STAFFING AND SALARY COSTS

B. CONSULTANT SERVICES

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
MARKETING	1,512	1,829	$ 46,088	$ 25.20
	1,512	1,829	$ 46,088	$ 25.20

Facility Name & ID Number WILLOWCREEK REHAB. & NURSING CENTE # 0041939 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Patricia Hartwig (1/1/00-5/19/00)	Administrator	0	$ 27,364
Wolfgang Voltz (6/27/00 - Present)	Administrator	0	28,714
Sandy Presson	Asst. Admin	0	4,948
Kevin Presson, Robert Pecker	Weekend Admin	0	11,098
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 72,124

B. Administrative - Other

Description	Amount
Quality Care Management - Corporate Allocation	$ 275,325
TOTAL (agree to Schedule V, line 17, col. 3)	$ 275,325
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Holleb & Coff	Legal	$ 4,082
Roy Burgonio	Legal	8,000
Goldberg, Katz & Stansen	Legal	1,130
Allen A. Lefkovitz	Legal	1,767
Sanchoff & Weaver	Legal	3,123
Mary Carmen Madrid Crost	Legal	11,400
Frost, Ruttenberg & Rothblatt	Accounting	18,947
Health Data Systems	Computer	5,962
Accu-Med Services	Computer	2,950
E- Solutions	Computer	5,559
See Attached Schedule		22,739
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 85,659

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 30,345
Unemployment Compensation Insurance	37,539
FICA Taxes	219,214
Employee Health Insurance	94,287
Employee Meals	12,737
Illinois Municipal Retirement Fund (IMRF)*	
401K Expense	11,855
Employee Benefits	8,559
Holiday Expenses	1,911
TOTAL (agree to Schedule V, line 22, col.8)	$ 416,446

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	20,749
Health Care Worker Background Check	
(Indicate # of checks performed 17)	204
Yellow Page Advertising	6,309
Promotional Advertising	11,654
License and Fees	575
Dues and Subscriptions	10,372
Allocated from Quality Care Management	2,652
Less: Public Relations Expense	( )
Non-allowable advertising	(11,654)
Yellow page advertising	(6,309)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 34,752

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	2,374
Allocated from Quality Care Management	454
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,828

**See instructions.

Facility Name & ID Number WILLOWCREEK REHAB. & NURSING CENTER, LLC # 0041939 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number WILLOWCREEK REHAB. & NURSING CENTER, LLC # 0041939 Report Period Beginning: 01/01/00 Ending: 12/31/00

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? NO

(2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. IL COUNCIL ON LTC = $4,813

(3) Did the nursing home make political contributions or payments to a politica action organization? YES If YES, have these costs been properly adjusted out of the cost report? YES

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YEARS

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ 1,749 Line 10

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? X YES NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ 66,978
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ 12,737 Has any meal income been offset against related costs? NO Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. $ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? N/A
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ N/A

(17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees

Date: **07/17/2000**

To: **Administrator/Cost Report Preparer**

From: **Office of Health Finance**

Re: 2000 Long Term Care Cost Report and Instructions on Diskette
Information Regarding the Lotus 5.0 and Excel 97 Versions of the Cost Report

Enclosed you will find a copy of the 2000 cost report and instructions on diskette. For 1999, the majority of nursing homes used the diskette to prepare their cost report. We would appreciate it if you could complete your 2000 cost report using this diskette.

If you choose not to use the diskette, you may print the 2000 cost report form and manually complete the report. If you do not have the ability to print the cost report form and instructions, please contact our office at 217/782-1630 to request a paper copy to be mailed to you.

As is stated on page 1 of the cost report instructions, this report should cover the facility's fiscal year ending in 2000. It is due on September 30, 2000, or ninety days after the close of the facility's fiscal year, **whichever comes later**. Please refer to the instructions for the remainder of the filing requirements.

There are two 2000 cost report files on the disk you have received. One file has been created for use with Lotus 5.0 for Windows. The other file has been created for use with Excel 97. A copy of the 2000 cost report instructions has been included on the diskette also. The name of the file is Instr00. It has been created for use with Word Perfect 6.1. Please use this 2000 diskette. **Printed copies of the report from the 1999 cost report diskette or earlier diskettes will NOT be accepted.**

Each page is on a separate worksheet. The file has been sealed. The cells where data is to b entered have been unprotected. Do not change the cost report form. We must have every form the same. Any changes made to the cost report form will cause us to consider the filed cost report incomplete until the form is correctly filed. Complete page one first. The facility name, IDPH ID# and the report period dates have been linked to each page. (Be sure to enter the IDPH licensed name of the facility.) **When entering data on pages 3 and 4, do not include decimals. Please round to whole numbers. When entering the years on page 12 do not enter various or other text in columns 2 or 3.**

Print macros have been written that will print each individual page or the entire report.

WARNING: Do NOT use drag & drop, cut or move commands. These commands may ruin the file and/or formulas. Then you will have to close the file and start from the last time you saved it.

As you know, save your work frequently to prevent losses of large amounts of information.

The cost report must be printed on 8 ½ by 14 size white paper with an 8 ½ by 14 image on the paper. To ensure an 8 ½ by 14 size image, check the paper size in the Printer Setup. When printing the cost report, be sure the "Selected Range" is checked. If "Current Worksheet" or "A Worksheets" are selected, the printed report will be smaller than it should be. These three selections appear in the Print dialog box. **Please do not reduce the image to 8 ½ by 11. We cannot accept a report with an 8 ½ by 11 image.** After printing the cost report, please review the copy for accuracy and completeness before mailing it to The Office of Health Finance. **Please send in the completed diskette with your paper copy, (being sure to make a copy of the diskette for your records).** Also, please make sure both the completed diskette and the paper copy agree prior to sending to our office.

Notes Applicable only to Lotus users

The entire cost report is in one file named Report00.wk4. A print preview button has been added to the bottom of each page. You may want to preview each page to ensure there are no problems before you print the entire cost report. To preview a page, click this button, then click File-Preview as normal. Also, macros have been written that will allow you to change the column width or row height of a cell or range of cells. **Only use these commands on the extra pages (24 through 33).** The print menu or the other macros menu will appear on the menu ba after you click the macro button. A macro that allows you to "Freeze Both Titles" has been added also. This will be helpful for data entry. **When saving the file in Lotus, please save it as a "WK4" file type instead of a "123" file type. To do this, click File-Save As, and then ensure the file type is "WK4".**

To copy worksheets that you have created into the blank pages at the end of the report, use Fi Combine. This will bring in the styles you used in your worksheet (except for the column width and the row height). This does not work if you are using Lotus 97. Extra sheets for pages 6, 8 and 12 have been included in the file. Click the macro buttons on these pages to make them available.

Notes Applicable only to Excel users

The entire cost report is in one file named Report00.xls. In an Excel 97 file that has been seale you can press the Tab key to go to the next unprotected cell. By pressing Shift-Tab, you can g to the previous unprotected cell. Extra sheets for pages 6, 8 and 12 have been included in the file. Click Format-Sheet-Unhide to see the sheets available. Also there are some blank unprotected sheets after "Page 23".

If you have any questions concerning the diskette, please call Randy Hulskotter at (217) 782-1630.

RH/cw